



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VICTORY MEDICAL CENTER
4303 VICTORY DRIVE
AUSTIN TX 78704

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative

Box Number 19

MFDR Tracking Number

M4-10-5183-01

MFDR Date Received

August 16, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "They are being denied for diagnoses used on other dates of service that were paid. They are being denied as duplicates. They are being denied as being bundled. All of these denials are incorrect and I cannot get a proper answer or solution from anyone about these payments/denials. I feel that they are incorrectly denying these bills, even when proper documentation to prove otherwise was submitted for their review."

Amount in Dispute: \$313.79

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The requestor did not include a position summary with the DWC060 response.

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2009, October 14, 2009 and October 30, 2009	97001-GP, 97140-GP and 97110-GP	\$313.79	\$308.72

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 1-(18) – Duplicate claim/service
- 1-(45) – Charges exceed your contracted/legislated fee arrangement
- 2-(97) – Payment is included in the allowance for another service/procedure
- * – Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review
- 2-(W1) – Workers Compensation State Fee Schedule Adjustment

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill in conflict with the NCCI edits?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "1-(45) – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 21, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The division completed NCCI edits to help identify edit conflicts that would affect reimbursement. The following was identified.

The Requestor seeks reimbursement for CPT codes 97001-GP, 97140-GP and 97110-GP rendered on October 7, 2009. The division finds that no NCCI edit conflicts were identified for CPT codes 97140-GP and 97110-GP as a result, reimbursement is determined pursuant to 28 Texas Administrative Code § 134.203 (c).

The Requestor seeks reimbursement for CPT codes 97140-GP and 97110-GP rendered on October 14, 2009. The division finds that no NCCI edit conflicts were identified for CPT codes 97140-GP and 97110-GP as a result, reimbursement is determined pursuant to 28 Texas Administrative Code § 134.203 (c).

The Requestor seeks reimbursement for CPT codes 97140-GP and 97110-GP rendered on October 30, 2009. The division finds that no NCCI edit conflicts were identified for CPT codes 97140-GP and 97110-GP as a result, reimbursement is determined pursuant to 28 Texas Administrative Code § 134.203 (c).

3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

The MAR reimbursement for CPT code 97001 is \$103.47, the requestor seeks reimbursement in the amount of \$94.55, therefore this amount is recommended for date of service October 7, 2009.

The MAR reimbursement for CPT code 97140 is \$33.40, therefore this amount is recommended for dates of service October 7, 2009, October 14, 2009 and October 30, 2009 for a total recommended reimbursement amount of \$100.20.

The MAR reimbursement for CPT code 97110 is \$41.57, the requestor seeks reimbursement in the amount of \$37.99, therefore this amount is recommended for dates of service October 7, 2009, October 14, 2009 and October 30, 2009 for a total recommended reimbursement amount of \$113.97.

Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of \$308.72 for dates of service October 7, 2009, October 14, 2009 and October 30, 2009.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$308.72.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$308.72 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		October 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.